Welcome to Thomas Eye Care!

Please complete all the information below.

Patient Name: _____

Insured or Responsible Party: _____

Address: _____

City: _____ State: _____ Zip: _____Best Phone#_____

Email Address: _____

Race: _____ Sex: _____ Marital Status (circle): Single, Married, Divorced, Widowed, Other.

Patient Social Security Number: _____ Date of Birth: _____

Employer (or School): _____Occupation (or grade): _____

Vision Insurance: _____ Medical Insurance: _____

Policy Holder's Name: _____Policy Holder's Employer: _____

Policy Holder's SS#: _____ Policy Holder's DOB: _____

Previous Eye Doctor: _____ Last Eye Exam: _____

Name of primary physician: _____Last Medical Exam: _____

Reason for today's visit: _____

Please list any sports or hobbies: _____

Allergies to medication & reaction: _____

Medications: (If you have a list we would be happy to make a copy) _____

Authorization to Pay Benefits to Physician

Private Insurance and Medicare Authorization for Assignment of Benefits and Information Release:

I, undersigned, authorize payment of medical benefits to Thomas Eye Care for any services furnished to me. I understand I am financially responsible for any amount not covered by my insurance.

Date: _____ Signed: _____

Insured or Responsible Party

Please answer the following questions; Do you.....

Work at the computer for long periods? Yes / No How many hours? _____

Spend a lot of time outside? Yes / No How many hours? _____

Have prescription sunglasses? Yes/ No

Have an interest in laser vision correction? Yes / No

Have you ever worn/ currently wear contact lenses? Yes / No

If yes, what kind of contact lenses? _____

Are you interested in contact lenses? Yes/ No

Social History (please circle)

Never Smoked

Former Smoker, how long ago? _____.

Current Smoker _____PPD _____Yrs.

Alcohol use, amount_____, how often_____.

Recreational drug use_____.

Family Medical History:	**Self or Family/Relationship**				
Blindness	No	Yes _____	Stroke	No	Yes_____
Cataracts	No	Yes _____	Cancer	No	Yes_____
Glaucoma	No	Yes _____	Cholesterol	No	Yes_____
Diabetes	No	Yes _____			
Heart Disease	No	Yes _____			
High Blood Pressure	No	Yes _____			
Macular Degeneration	No	Yes_____			
Muscle Imbalance	No	Yes _____			
Kidney Disease	No	Yes _____			

Patient Medical History:

Please indicate if you are currently experiencing problems/ symptoms in the following areas.

Yes No

____ ____ Constitutional (Fever, weight loss/gain, fatigue)

____ ____ Ear /nose /throat/mouth/dental. (Ulcers, infections, hearing loss)

____ ____ Cardiovascular. (Heart attack, high cholesterol, high blood pressure, stroke)

____ ____ Respiratory (Cough, shortness of breath, asthma, COPD)

____ ____ Neurological (Vertigo, tingling, numbness, headache, seizures)

____ ____ Musculoskeletal (Weakness, joint pain, back pain, arthritis)

____ ____ Endocrine (Thyroid disorders, diabetes)

____ ____ Hematological/ Lymphatic (Anemia, leukemia, blood disorders)

____ ____ Allergic/ Immunology (HIV, immune disorder, seasonal allergies)

____ ____ Genitourinary (Kidney stone, dysfunction)

____ ____ Psychiatric (Depression, anxiety, attention disorder)

____ ____ Integumentary (Psoriasis, eczema)

EYE HISTORY

Have you had or are you currently experiencing any of the following?

Yes	No		Date/Type	Yes	No	
____	____	Eye Injury	_____	____	____	Flashes of Light
____	____	Eye Surgery	_____	____	____	Headaches
____	____	Eye Disease	_____	____	____	Redness

Yes	No		Yes	No	
____	____	Lazy Eye	____	____	Double Vision
____	____	Cataracts	____	____	Blurry Near
____	____	Glaucoma	____	____	Blurry Distance
____	____	Itching	____	____	Burning
____	____	Soreness	____	____	Sensitivity to light
____	____	Tearing	____	____	Gritty feeling in eye
____	____	Dryness	____	____	Floaters
____	____	Eyestrain	____	____	Poor Night Vision/Glare

_____

Patient or responsible party signature **Date**

HIPAA Compliance Patient Consent Form

Please tell use with whom we are allowed to discuss and/or disclose your personal health information.

Please circle all that apply:

Myself only **Spouse** **Parents** **Siblings**

Adult Children **Personal Representative** **Employer**

Please print the name(s) of the persons above: _____

_____

_____

My signature below authorizes the release of medical information to any specialist I may be referred to and to process insurance claims/applications, prescriptions and lab work.

I understand that under the HIPAA act, I have certain rights to privacy regarding my protected health information. I understand this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosers of my health information. I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations.

Patient Name (please print) _____

Signature of patient or responsible party: _____

Relationship to patient (circle): **Self** **Parent** **Step-Parent** **Foster Parent** **Guardian** **Other**

If other, describe: _____

Date_____